12

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17861

1. DECEASED-NAME (Type or print) First / Middle / Last	Charles Laird Ellwanger
2a. DATE OF DEATH Month / Day / Year	7-25-74
2b. HOUR	M
3. SEX	Male
4. RACE	Cau.
5. DATE OF BIRTH	4-25-05
6. AGE (In years lost birthday)	69 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Md.
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. COUNTY OF DEATH	Caroline Md.
10. CITY OR TOWN OF DEATH	Greensboro
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	None
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Farmer
12b. KIND OF BUSINESS OR INDUSTRY	Farming
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.
13b. COUNTY	Caroline
13c. CITY OR TOWN	Greensboro
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET AND NUMBER	None
14. FATHER'S NAME First / Middle / Last	Thomas J. Ellwanger
15. MOTHER'S MAIDEN NAME First / Middle / Last	Elizabeth Ellen Bullock
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No
16b. SOCIAL SECURITY NO.	218-36-1055
17. INFORMANT Address	Margaret Ellwanger Greensboro, Md

00

05

1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

185X

IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of the lungs

DUE TO, OR AS A CONSEQUENCE OF (c) Mesenteric nodes and liver with ascites

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☐	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

X

22a. **I certify** that (I) (this hospital) attended the deceased from May 10, 1973, to July 25, 1974, that (I) (we) last saw the deceased alive on July 25 1974, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Charles H Stonesifer DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED	July 27'74
22d. PHYSICIAN'S NAME (Type)	Charles H. Stonesifer, M.D.
22e. ADDRESS	Greensboro, Md. 21639

1

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial
23b. DATE	7-28-74
23c. NAME OF CEMETERY OR CREMATORY	Greensboro Cemetery
23d. LOCATION (City or Town) (County) (State)	Greensboro Caroline Md.
24. FUNERAL DIRECTOR	John S Boulais
ADDRESS	Greensboro, Md.
25a. REC'D BY REGISTRAR DATE	AUG 01 1974
25b. REGISTRAR'S SIGNATURE	Sidney H Norton

VR A15 (4)
45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17862

1. DECEASED-NAME (Type or print) First Middle Last: Mary Della Holzman
2a. DATE OF DEATH Month Day Year: 7-24-74
2b. HOUR: M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 5-13-04
6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Del.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Caroline Md.
10. CITY OR TOWN OF DEATH: Greensboro
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Maple Ave.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Caroline
13c. CITY OR TOWN: Greensboro
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: Maple Ave.
14. FATHER'S NAME First Middle Last: Samuel Edge
15. MOTHER'S MAIDEN NAME First Middle Last: Della Pritchett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO.:
17. INFORMANT: Albert W. Holzman Address: Greensboro, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Chronic Congestive Cardiac Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic C.V.Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Residual Spastic Hemiparesis due to past CVA

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from June 3, 1972, to July 24, 1974, that (I) (we) last saw the deceased alive on July 24 1974 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: July 26'74
22d. PHYSICIAN'S NAME (Type): Charles H. Stonesifer, M.D.
22e. ADDRESS: Greensboro, Md. 21639

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-27-74
23c. NAME OF CEMETERY OR CREMATORY: Greensboro Cemetery
23d. LOCATION (City or Town) (County) (State): Greensboro Caroline Md.
24. FUNERAL DIRECTOR: [signature] ADDRESS: Greensboro, Md.
25a. REC'D BY REGISTRAR DATE: AUG 01 1974
25b. REGISTRAR'S SIGNATURE: [signature]

1752

8

1 FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible] Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17863

1. DECEASED-NAME (Type or Print) First Middle Last: Helen R. Mossop

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month Day Year: 7-5-1974

2b. HOUR: 8:25 PM

3. SEX: Female

4. RACE: Cau.

5. DATE OF BIRTH: 1-13-1900

6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.

2c. DATE PRONOUNCED DEAD Month Day Year: 7 5 1974

2d. HOUR: 9:25 PM

7a. BIRTHPLACE (State or foreign country): Pa.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Caroline Md.

10. CITY OR TOWN OF DEATH: Ridgely

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): The Benedictine School

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Pa.

13b. COUNTY: Del.

13c. CITY OR TOWN: Phila.

13d. INSIDE CITY LIMITS? YES ☒ NO ☒

13e. STREET AND NUMBER: 5016 Palmetto St.

14. FATHER'S NAME First Middle Last: Frank Smith

15. MOTHER'S MAIDEN NAME First Middle Last: Anne O'hagan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 161-03-2872

17. INFORMANT: Lewis Mc Cartney ADDRESS: Ridgely, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Cerebral Hemorhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

4122

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic CV disease — yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Gene alized arteriosclerois — yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Harold B. Plummer M.D

ADDRESS (Street, city, town, or county): Preston Caroline

22b. DATE SIGNED: 7/6/74

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 7-10-74

23c. NAME OF CEMETERY OR CREMATORY: Holy Sepulcher

23d. LOCATION (City or Town) (County) (State): Cheltenham Del. Pa.

24. FUNERAL DIRECTOR: John E. Boulais ADDRESS: Greensboro, Md.

25a. REC'D BY REGISTRAR DATE: JUL 9 1974

25b. REGISTRAR'S SIGNATURE: [signature]

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17864

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year	2b. HOUR
Stanley		Torkarski	6-30-74 19	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	Cau.	9-22-17	56 YRS.					6-30-74 19	M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Pa.	U.S.A.		Caroline Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Greensboro	S. Main St.	Disabled	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Caroline	Greensboro	YES ☒ NO ☐	S. Main St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph		Torkarski	Mary		Kwolik

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	078-05-1120	Dorothy Porter	Greensboro, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probably Cerebral Thrombosis

4339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Charles H. Stonesifer M.D.

EXAMINER'S NAME (Type) Charles H. Stonesifer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ Sub

ADDRESS (Street, city, town, or county) Greensboro, Md.

22b. DATE SIGNED July 1 '74

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-6-74	Holy Redeemer Cemetery	Philadelphia, Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John E. Boulden	Greensboro, Md.	JUL 8 1974	Sidney Winton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, [illegible] the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible] 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

2 B

FOR 1 - STATE REGISTRAR Item#13a FilmG475 9/3/74 sy

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 17865

1. DECEASED NAME (TYPE OR PRINT) FIRST CALVIN MIDDLE L. LAST TURNER

2a. DATE OF DEATH MONTH JULY DAY 26 YEAR 1974

2b. HOUR M

3. SEX MALE

4. RACE WHITE

5. DATE OF BIRTH MONTH OCT. DAY 5 YEAR 1911

6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND CAROLINE CO.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE MD.

10. CITY OR TOWN OF DEATH FEDERALSBURG

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 206 VESPER AVE.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MGR.-GROCERY STORE

12b. KIND OF BUSINESS OR INDUSTRY STORE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md.

13b. COUNTY N.Y. CAROLINE

13c. CITY OR TOWN FEDERALSBURG

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS 206 VESPER AVE.

14. FATHER'S NAME FIRST JOSEPH MIDDLE THOMAS LAST

15. MOTHER'S MAIDEN NAME FIRST ROXANNA MIDDLE TODD LAST TURNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) —

16b. SOCIAL SECURITY NO. 216-10-4832

17. INFORMANT ADDRESS Anna C. Turner, 206 Vesper Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease — ?

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis — ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

X

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/5 19 60 to 7/26/ 19 74, that (I) (we) last saw the deceased alive on 7-26-74 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE H. R. Trapnell

DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED 7/29/74

22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. Trapnell, M.D.

22e. ADDRESS Federalsburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b. DATE 7/28/74

23c. NAME OF CEMETERY OR CREMATORY Hill Crest

23d. LOCATION CITY OR TOWN Federalsburg COUNTY MD. STATE

24. FUNERAL DIRECTOR NAME Frampton Funeral Home ADDRESS Box 43, Federalsburg, Md.

25a. DATE REC'D. BY REGISTRAR AUG 6 1974

25b. REGISTRAR'S SIGNATURE Sidney J. Norton

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/73 (VR A 15(4))

Items 21a--21f Film 4

8/14/74 mh

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17866

1. DECEASED-NAME (Type or Print): First: William | Middle: M. | Last: Walls

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 7 Day 21 Year 1974

2b. HOUR: 1 P.M.

3. SEX: Male

4. RACE: Cau.

5. DATE OF BIRTH: 6-24-72

6. AGE (In years last birthday): 2 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month 7 Day 21 Year 1974

2d. HOUR: 1:30 P.M.

7a. BIRTHPLACE (State or foreign country): Md.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Caroline Md.

10. CITY OR TOWN OF DEATH: Goldsboro

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rt 311

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): None

12b. KIND OF BUSINESS OR INDUSTRY: None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Caroline

13c. CITY OR TOWN: Goldsboro

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET AND NUMBER: None

14. FATHER'S NAME: First: Robert | Middle: S. | Last: Walls

15. MOTHER'S MAIDEN NAME: First: Susan | Middle: | Last: DeFord

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: None

17. INFORMANT: Robert S. Walls ADDRESS: Goldsboro, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Accidental Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

9109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 1 P.M. 7 21 1974

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Fell in pond at own home-

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home

21f. LOCATION Street or R.F.D. No. / City or Town: Goldsboro / County: Caro. / State: Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Charles H. Stonesifer, M.D. Sub

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: July 22, 1974

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 7-24-74

23c. NAME OF CEMETERY OR CREMATORY: Denton Cemetery

23d. LOCATION (City or Town) (County) (State): Denton Caroline Md.

24. FUNERAL DIRECTOR: John E. Boulais ADDRESS: Greensboro, Md.

25a. REC'D BY REGISTRAR DATE: JUL 25 1974

25b. REGISTRAR'S SIGNATURE: Sidney H. Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Po may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE HEALTH DEPT.

VR A15ME (5)
10M - 1/69